*ATTENTION ESTATE: The Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

Local No. 2403-95

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

15 CC's Rees Funeral Home Inc. Brady Chapel 2781 Central Ave. Lake Station In. 46405

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-1-10-3

TYPE/PRINT IN PERMANENT BLACK INK

DECEDENT

1. DECEASED—NAME (First Middle Last): JOANNE KOMENDA
2. SEX: Female
3a. TIME OF DEATH: 9:31P M
3b. DATE OF DEATH (Month Day Yr): October 21, 1995
4. *SOCIAL SECURITY NUMBER: 362-32-3607
5a. AGE—Last Birthday (Years): 62
5b. UNDER 1 YEAR: Months / Days
5c. UNDER 1 DAY: Hours / Minutes
6. DATE OF BIRTH (Mo. Day. Yr): SEP 23, 1933
7. BIRTHPLACE (City and State or Foreign Country): McHENRY, KENTUCKY
8a. WAS DECEDENT A U.S. VETERAN? No
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A
9a. PLACE OF DEATH (Check only one. See instructions): HOSPITAL ☐ Inpatient ☒ ER/Outpatient ☐ DOA; OTHER ☐ Nursing Home ☐ Other (Specify) ☐ Residence
9b. FACILITY NAME (If not institution give street and number): ST. MARY MEDICAL CENTER
9c. CITY, TOWN OR LOCATION OF DEATH: HOBART
9d. COUNTY OF DEATH: LAKE
10. MARITAL STATUS (Specify): Married
11. SURVIVING SPOUSE (If wife, give maiden name): CASIMIR C. KOMENDA
12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): DOMESTICS MANAGER
12b. KIND OF BUSINESS/INDUSTRY: VENTURE DEPT. STORE
13a. RESIDENCE—STATE: Indiana
13b. COUNTY: LAKE
13c. CITY, TOWN OR LOCATION: LAKE STATION
13d. STREET AND NUMBER: 3011 CENTRAL AVE.
13e. ZIP CODE: 46405
13f. INSIDE CITY LIMITS: ☐ No ☒ Yes
13g. ON A FARM? ☒ No ☐ Yes
14. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEDENT OF HISPANIC ORIGIN? ☒ No ☐ Yes (If yes specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—American Indian, Black, White, etc. (Specify): WHITE
17. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):

PARENTS

18. FATHER'S NAME (First Middle Last): ZOBUS HAWES
19. MOTHER'S NAME (First Middle Maiden Surname): GOLDA JOLLY

INFORMANT

20a. INFORMANT'S NAME (Type/Print): CASIMIR C. KOMENDA
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3011 CENTRAL AVE., LAKE STATION, IN 46405
20c. Relationship: Husband

DISPOSITION

21a. METHOD OF DISPOSITION: ☐ Burial ☒ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify)
21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OCT 25, 1995 CALVARY CREMATORY
21c. LOCATION—City or Town, State: PORTAGE, INDIANA
22a. EMBALMER'S NAME: JAMES J. KRAUSE
22b. EMBALMER'S LICENSE NO.: FD01006463
23. WAS DEATH REPORTED TO CORONER? ☒ No ☐ Yes
24a. SIGNATURE OF FUNERAL DIRECTOR: Kenneth P. Stawes
24b. LICENSE NUMBER (of Licensee): FD08900027
25. NAME, ADDRESS AND LICENSE NUMBER OF FUNERAL HOME: FH19300009 REES FUNERAL HOME, BRADY CHAPEL 3781 CENTRAL AV LAKE STATION, IN4640

CAUSE OF DEATH

26. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter nonspecific terms such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death)

a. Acute Nonlymphocytic Leukemia — Approximate Interval Between Onset and Death: 1½ years
b. DUE TO (OR AS A CONSEQUENCE OF)
c. DUE TO (OR AS A CONSEQUENCE OF)
d. DUE TO (OR AS A CONSEQUENCE OF)

Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last

PART II. Other significant conditions. Conditions contributing to death but not previously stated in Part I

27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no): No
28a. WAS AN AUTOPSY PERFORMED? (Yes or no): No
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

CERTIFIER

29a. CERTIFIER (Check only one): ☐ CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ HEALTH OFFICER On the basis of examination and/or investigation in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. ☐ CORONER On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mary Klein MD
29c. MEDICAL LICENSE NO.: 01034294
29d. DATE SIGNED (Month Day Year): October 24, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print): MARY KLEIN MD, 1190 NORTH STATE ROAD 49, PORTER, IN 46304

HEALTH OFFICER

31. HEALTH OFFICER'S SIGNATURE: Alexander S. Williams M.D.
32. DATE FILED (Month Day Year): 10/24/95

33. MANNER OF DEATH: ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Could not be Determined ☐ Homicide
34a. DATE OF INJURY (Month, Day, Year)
34b. TIME OF INJURY
34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED
34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)
34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g. DATE PRONOUNCED DEAD (Month Day Year)
34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes specify driver, passenger, pedestrian, etc.

000427

95 NOV -6 PM 3:00

STATE OF INDIANA LAKE COUNTY FILED FOR RECORD

MARGARET ... RECORDER

FILED NOV 6 1995 ... AUDITOR LAKE COUNTY

95 067144

Key # 20-56-5

CK 2016

SDH06-004 State Form 10110 (R4/3-93) Deathcer/PD 1